HANOVER & DISTRICT HOSPITAL

ECHOCARDIOGRAPHY REQUISITION

TRANSTHORACIC ECHOCARDIOGRAM

Registration/ Appointment Booking Office: 519-364-2340 ext 260

To book a test, please FAX requisition to 519-364-0062

PATIENT IDENTIFICATION:			
MRN/ID:	❒ Outpatient	❒ Inpatient	❒ Isolation
Legal Name on HC: *(last, first)*			
DOB: *(yyyy-mmm-dd)*	Gender:		
Telephone:	Alternate Telephone:		
Health Card No:	Version:	Expiry:	
City:	Province:	Postal Code:	
Priority: ❒ Urgent	❒ Routine	❒ Days	❒ Weeks

PHYSICIAN IDENTIFICATION:	
Referring Physician:	Physician Number:
Referring Physician's Contact Info: *(address, telephone, fax)*	CC Report to:

Patient Location: ❒ Home ❒ Hospital: _____

Is this a pre-operative assessment? ❒ Yes ❒ No Scheduled Surgical Date:

Has the patient previously been seen by a Cardiologist? ❒ Yes ❒ No
If yes, please specify:

Has the patient had an Echo in the past 6 months? ❒ Yes ❒ No
Date of last Echo:

INDICATION: (Check all that apply) ***Requisitions without appropriate indication/clinical information will be returned to sender.***

❒ Prior MI	❒ Cardiac Cath	❒ CABG	❒ Valve Replacement
❒ Mechanical	❒ Tissue *Model:* _____		❒ Chest Pain
❒ Dyspnea	❒ Palpitations	❒ AFib	❒ Syncope
❒ Murmur: _____		❒ LV Dysfunction	❒ Cardiomyopathy
❒ Aortic Disease	❒ Source of embolus	❒ Pericardial Disease	❒ Chemotherapy
❒ LVH	❒ RV Dysfunction	❒ Congenital	❒ Pulmonary HTN
❒ Valve Disease: _____		❒ Smoker	❒ Diabetic
❒ Dyslipidemia	❒ Hypertension	❒ Stroke/TIA	❒ PVD
❒ Family History CAD	❒ Abnormal ECG		

Patient Weight: Patient Height:

CLINICAL INFORMATION:

Office Use Only	Date Requisition Received: _____ Scheduled Appointment Date and Time: _____ Patient Notified: ❒

Physician Signature: **Date of Request:**